review by the Agency or the Agency's authorized representative.

F. Surgical procedures identified by AHCA in Appendix E of the Hospital Coverage and Limitations Handbook as incorporated by reference in Rule 59G-4.150, F.A.C. shall require a second opinion, prior authorization or post authorization if stipulated by Rule 59G-4.150, F.A.C. Failure to meet the requirements shall result in the disallowance of such charges associated with the surgical procedures. Appropriate adjustments shall be made to the Florida Medicaid Log.

G. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the Florida Medicaid Information System Update.

H. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.101, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205 (1995), this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. These ceilings shall not apply to rural hospitals and specialized psychiatric hospitals.

C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in G. below.

D. Changes in individual hospital rates shall be effective from July 1, through December 31 and January 1 through June 30 of each year.

E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the Medicaid fiscal

agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

F. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings. Providers shall be notified of the new reimbursement ceiling and rates prior to each June 1 and December 1.

G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.
2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date the rate was established, or if the change is not material.
3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.

4. Where a hospital's cost report contains a partial period's costs for new services or a capital improvement, the hospital shall attach for the Medicaid Cost Reimbursement section's consideration a 12-month projection of costs for the new service or capital improvement.

5. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

H. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 59-1.018(4), F.A.C., and Section 120.57 Florida Statutes.

I. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established.

J. In accordance with Section 2302 of Public Law 98-369, the Deficit Reduction Act of 1984, the reimbursement rates for laboratory and pathology services shall be the lower of: the hospital's charges or; the Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk or field audits.
   b. To compensate for new, expanded, or discontinued services not accounted for in the reporting year; the hospital shall identify and submit budget data which shall specify all such new, expanded, or discontinued services within 60 days after such services changed.
   c. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 405.460 (1995).
3. Determine Medicaid outpatient variable costs defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and either September 30, or March 31, the midpoint of the rate semester for which the new rate is being calculated. The adjustment shall be made utilizing the latest available projections as of March 31 or September

30 for the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.

5. Divide the inflated Medicaid outpatient variable costs by the latest available Health, Recreation and Personal Services component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.

7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

   a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. This cost based ceiling shall not apply to rural hospitals and specialized psychiatric hospitals. For hospitals participating in

the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

b. For rate periods beginning with the July 1,1993 rate period, the target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

$$1 + 1.4 \times \left[\frac{\text{Midpoint of the prospective rate period using appendix B}}{\text{Midpoint of the current rate period Using Appendix B}} - 1 \right]$$

This target ceiling shall not apply to rural hospitals and specialized psychiatric hospitals.

B. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report as follows:

a. To reflect the results of desk and field audits.

b. To compensate for new, expanded, or discontinued services not accounted for in the reporting year. The hospital shall include identification of budget data within 60 days after such services changed.

c. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1995).

3. Determine Medicaid outpatient variable costs as defined in Section X.

4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.

5. Establish the variable cost rate as the lower of:

   a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.

   b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings.

6. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX Outpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204 (1995).

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations (1995).

IX. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Outpatient Hospital Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. AHCA - Agency for Health Care Administration, also known as the Agency.

C. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with the Principles of Reimbursement for Provider Costs, as defined in HCFA PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the Florida Title XIX Outpatient Hospital Reimbursement Plan.

D. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

E. Eligible Medicaid Recipient - "Recipient" or "Medicaid recipient" means any individual whom the department, or the Social Security Administration on behalf of the